Hemophilia Additional Nursing Visit

Member and Medication Information (required)		
Member ID:	Member Name:	
DOB:		
Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:
Nursing Visit Information (required)		
Total additional time requested:	Total additional time requested:	
FAX FORM AND RELEVANT DOCUMENTATION INCLUDING: LABORATORY RESULTS, CHART NOTES and/or UPDATED PROVIDER LETTER TO 855-828-4992		

Criteria for Approval (at least one of the following must be met):

- ❑ Patient experienced one or more bleeding episode(s).

  Episode 1: Medication used: _____ Dose/Protocol: _____

  Episode 2: Medication used: _____ Dose/Protocol: _____

- ❑ Patient required delivery of additional factor/product/supplies
  Item(s) required: _____ Reason: _____

- ❑ Patient/caregiver required additional education/training.
  Education/training given: _____ Reason: _____

- ❑ Patient/caregiver unable to administer factor/product without the assistance of a Utah Medicaid-contracted healthcare professional.

- ❑ Due to bleeding, patient visited the ER or was admitted to hospital.

Note:

- ❖ Reimbursement is based upon 15-minute units and capped at 8 units per month.
- ❖ Additional in-home visits may be authorized by the department on a case-by-case basis.

Authorization: One (1) month

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date